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Delivering clinical case management for frequent callers to ambulance services

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Ambulance services in England are playing an increasing role in the provision of care. Their role has changed from one of picking up patients in the community and dropping them off at an emergency department (ED), to more advanced care models. These now include the provision of clinical advice over the telephone (hear and treat), the treatment of patients on-scene (see and treat), and the more traditional conveyance to the ED.[1] These changes are occurring during a prolonged period of increased demand on all areas of emergency care, including a 47% rise in ED attendance over 15 years.[2] Further, it is known that frequent users of healthcare use a disproportionate amount of resources.[3]

Clinical Case Management for Frequent Callers

The paper by Edwards et al. [include paper reference here] provides one of the first examples of delivering interventions for frequent callers to an English ambulance service, and is one of few publications on the topic internationally.[4] There are three notable findings that will be discussed in this commentary:

(1) Frequent callers were found to be heterogeneous with 95 (86%) falling within more than category;
(2) Ten different types of interventions were used, although 90 (82%) patients received five or fewer;
(3) The interventions as a whole showed a reduction in median calls from five per month pre-intervention to zero per month post-intervention.

These findings are of importance for both research and practice. Firstly, the heterogeneous profile of patients within this study suggests that, similar to frequent users of the ED,[5] there are potential subgroups of frequent callers. However there is still much research to be done before they can be fully identified due to the paucity of research within ambulance services.[4]

Secondly, that there were ten intervention types demonstrates the complexity of care associated with this group of patients who may require the support of various health and social care services. Whilst this potentially serves as a note of caution, complexity should be sought to be understood rather than avoided. Indeed this could serve as an opportunity for ambulance services, which have

been recognised as being able to coordinate and lead the integration of health and social care services,[6] which coincides with perspectives on transforming the health care system for the delivery of more integrated care.[7]

Thirdly the reduction in calls is a promising indication that, from an ambulance service perspective, providing interventions can reduce service usage and possibly free up resources that are needed elsewhere. Nevertheless, caution should be noted when interpreting the impact of clinical case management. As Edwards et al.[include paper reference here] have acknowledged, the lack of a control group means that reductions in usage cannot be fully attributed to the interventions. Roland and Abel[8] have recently cautioned against ignoring regression to the mean; given that patients were registered for up to 24.5 months at the maximum end of the range, it is entirely possible that this contributed to the result. Further research would provide an insight into the extent that regression to the mean has impacted on the study outcome.

What does quality mean to frequent callers?

There is a risk that frequent callers, once identified by ambulance services, are simply passed to another service[9] so that budgetary rather than patient needs are met. As such it must be remembered that many patients will be frequently calling ambulance services because they are not receiving adequate care, as opposed to calling for vexatious reasons.[5] Qualitative research is needed to identify outcomes that are of importance to frequent callers and to understand the mechanisms by which interventions for frequent callers work.

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